

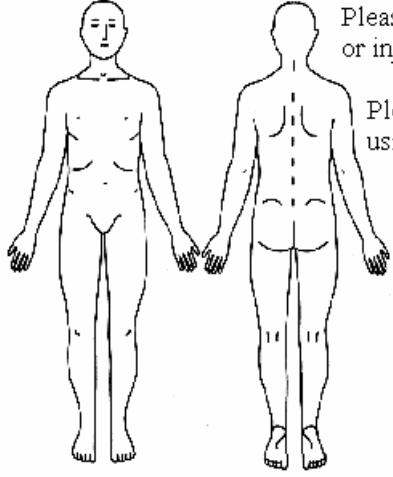
Name: _____ Age: _____ Date: _____ Sex: M F SSN #: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ B-Day _____ Have you been to a chiropractor before? Y N

Employer _____ Employer's Address _____ City/State/Zip _____

Show Us Where It Hurts



Please mark the area(s) of pain or injury on the drawing.
Please note the type of pain by using the symbols below.

- Sharp/stabbing >>>
- Dull/Achy ###
- Numb/Pins+needles OOO
- Burning ***

On a scale of 1-10, 10 being the worst pain you have ever had, how would you rate your pain at this time? _____
How would you rate it when it first started? _____
MOI: _____
Prov: _____
Pall: _____
Other Notes: _____

Tell Us About What Hurts

What is your main complaint? _____

When did it start? _____ Is it better or worse now? _____ What % of the day is it present? _____

Have you ever injured this area before? Y N If yes when and how? _____

Medical Information

Have you or any of your immediate family had any of the following? (circle all that apply)
stroke, cancer, hypertension, diabetes, heart attack, arthritis, other _____
Condition? _____ who? _____ Age? _____
Condition? _____ who? _____ Age? _____

Have you ever seen another doctor for this condition? MD _____ DO _____ DC _____ DDS _____ Dr's Name _____

Have you ever experienced any of the following? Unexplained weight loss, night pain, or pain at rest, bowel or bladder problems, dizziness, chest pain, weakness in arms or legs, difficulty breathing, fractures, or any other injury/illness requiring medical attention: _____

Have you had any x-rays? Why were they taken? _____

Have you had surgery? Y N If Yes, when and why? _____

Please list any medications you are taking: _____
What are they for? _____

Have you ever used prescription contraceptives? Y N When? _____ How long? _____

Have you had or do you presently have cancer? Y N If yes, when was the initial diagnosis made? _____

What type of cancer? _____ What type of treatment? _____ Date of last bone scan: _____

Date of last mammogram? _____ Pelvic exam? _____ Breast exam? _____

What were the results of the above tests? _____

Are you postmenopausal? Y N Approximate date of onset? _____ Are you on hormone replacement? Y N

Vitals:
Pulse: _____ BPM Temp: _____ Resp: _____ RPM BP L: _____/_____/_____ BP R: _____/_____/_____ Georges: + --

Ht _____ Wt. _____